Claim Form

IMPORTANT INSTRUCTIONS: (please read them carefully)

i. In order for us to provide you with fast and efficient service, please complete the Form accurately in CAPITAL LETTERS. Photocopies of this form can also be used.

ii. Filled forms should be sent to: Health Division, Takaful Pakistan Limited, Dadex House 34-A/1 2nd Floor, Block-6, P.E.C.H.S., Shahrah-e-Faisal Karachi within 30 days of the expense incurred date. Please attach the following along with the form:

a. Proper itemized bill(s) and payment receipt(s) as highlighted below. These should be issued on the official bill/receipt book of the Hospital/Physician/Surgeon/Pharmacy/Laboratory.

Proper hospital bill in original highlighting the type of accommodation used (room type) and break up of total bill according to:
1- Room charges **2-** Lab tests and Radiology Charges **3-** Consultation charges **4-** Surgeons fee with details (if any)
5- Operation Theatre Charges (if any) **6-** Anesthesia charges (if any) **7-** Medicines (used during hospitalization)
8- Other miscellaneous medical expenses like blood & oxygen, etc.

b. Laboratory, or Radiology reports along with doctors reference for the same.

c. Itemized bill(s) of medicines purchased supported by Physicians prescription specifying the quantity and respective dosage.

d. Hospital discharge summary / Clinical Summary (in case of Hospitalization).

e. Copy of Birth Certificate (in case of delivery/child birth)

TO BE COMPLETED BY THE EMPLOYEE / PATIENT:

Name of the Employer:		Policy Number:	
Name of the Employee:		Health ID #	
Name of Patient:		Amount Claimed (Rs.)	
Date of Birth:		Relationship with the Employee:	

Exact duration of illness/injury claimed for:

Have you ever suffered from the same/similar illness or disease in the past ? YES ☐ NO ☐

Name of Patient	Nature of illness/Disability & Treatment Received	Period of Disability			Remarks
		Month	Year	Duration	

IN CASE OF HOSPITALIZATION:

Was this An Emergency Treatment ☐ or Elective/Planned Treatment? ☐

Was Pre-Authorization Taken & Approved? ☐ YES ☐ NO

Date of Admission: Date of Discharge:

Is the patient entitled to any other benefit or compensation from any other source whatsoever? If so name the company or the association or source, and give amount of benefit payable by each:

DECLARATION BY THE EMPLOYEE/PATIENT:

I hereby certify that all answers, and all documents submitted with the claim form are complete and true to the best of my knowledge and belief. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance/takaful company or any company, institution or any other person who has any record or information about me and/or of my family members to provide Takaful Pakistan Limited with the information, including copies of their records with reference to any sickness or accident, any treatment, examination, advice or hospitalization. Any photocopy of this declaration/authorization shall be taken as the original copy

Signature of Patient/Employee | Signature & Stamp of the Employer | Date

To Be Completed by the Attending Physician/Hospital:

Patient Name:

Primary Diagnosis | Secondary Diagnosis:

When did the symptoms first appear? Day | Month | Year

When did the patient first consult you for this complain? Day | Month | Year

Has the patient ever suffered from/been treated for the same OR related condition? If yes, please provide details with dates:

In case of Hospitalization:

Name & Address of the Hospital:

Phone Number: | Fax Number:

Hospital Admission Date: | Discharge Date:

Emergency or Elective Treatment?

Details of Surgical, Gynecological or Obstetrical procedure performed, (if any):

Type of Anesthesia Used (local/general):

Is further treatment anticipated? ☐ Yes ☐ No (If Yes, pl. explain _____)

I, hereby certify that my answers to the foregoing questions are correct and true, to the best of my knowledge and belief.

Signature & Stamp of the Attending Physician:

Name & Address:

Phone Number: | Fax #

Credentials/Qualifications: | Date:

For Takaful Pakistan's Use Only

Policy Number: | Employee Health ID#.

Claim Number: | Authorization Number

Claim Received On: | Claim Entered By:

Claim Approved By: | Claim Cheque Dispatched On:

TAKAFUL PAKISTAN LIMITED
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